REQUEST for a DEPARTMENT REVIEW

INSTRUCTIONS

Michigan Department of Community Health

Use this form to request a Department Review. A Department Review is an impartial review of a decision made by the Michigan Department of Community Health (or one of its contracted agencies) that the appellant (beneficiary, resident, patient, consumer, or responsible party) believes is inappropriate.

GENERAL INSTRUCTIONS:

- Read ALL Instructions FIRST, then remove this instruction sheet before completing the form.
- Complete **Section 1.**
- Complete **Section 2 ONLY** if you want someone else to represent you at the Department Review.
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM (Yellow) copy and save with the Instruction Sheet for your records.
- If you have any questions, please call toll free **1 (877) 833 - 0870**.
- After you complete this form, mail it to:

ADMINISTRATIVE TRIBUNAL and APPEALS DIVISION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909

AUTHORIZED REPRESENTATIVE:

You may choose to have another person represent you at a review.

- This person can be anyone you choose but he/she must be at least 18 years of age.
- This person may request a review for you.
- This person may also represent you at the review.
- You must give this person written permission to represent you by signing the form in Section 2.

IMPORTANT:

After the Administrative Tribunal receives your request for a Department Review, your review will be scheduled and a notice of the date and time of the review will be mailed to you and/or your representative.

Authority:	42 USC 1397aa; 42 USC 700 et seq.; MCLA 330.1001 et seq.; MCLA 400.1 et seq.; MCLA 333.1101 et seq.; Department of Community Health Appropriations Act.
Completion:	Is voluntary.

- The Department of Community Health is an equal opportunity employer, services, and programs provider.
- If you need help with reading, writing, review, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية مينتشيجن.	**1 (877) 833 - 0870**

See the Request Form Underneath

REQUEST FOR A DEPARTMENT REVIEW

Michigan Department of Community Health

IMPORTANT:

- Read the instruction sheet first.
- See the instruction sheet for non-discrimination information.

ADMINISTRATIVE TRIBUNAL and APPEALS DIVISION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909 **1 (877) 833-0870**

SECTION 1 – Applicant Information:

Applicant's Name			Telephone Number ( )	Social Security Number
Address (No. & Street, Apt. No., etc.)			Medicaid ID Number	Case Number
City	State	ZIP Code	Applicant's or Parent/Guardian Signature	Date Signed
Name of Parent or Guardian				

Please check (X) the program you are applying for or receiving:

☐ TMA-Plus ☐ MIChild ☐ MOMS ☐ Children's Special Health Care Services

☐ Other (please explain):

I WANT TO REQUEST A REVIEW: The following are my reasons for requesting a review. ***Use Additional Sheets if Needed.***

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a Department Review?

☐ **NO** ☐ **YES** *(Please Explain Here):*

SECTION 2 – Authorized Department Review Representative Information:

Read the information near the top of the Instruction Sheet FIRST

Has someone agreed to represent you at a Department Review?

☐ **NO** ☐ **YES** *(If Yes, complete the information below)*

Name of Representative			Representative Telephone Number ( )	
Address (No. & Street, Apt. No., etc.)			Representative Signature	Date Signed
City	State	ZIP Code		